

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041754

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10219

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED OCT 17 1963

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Length of stay in lb <b>St. Louis County</b>		c. CITY OR TOWN <b>St. Louis County</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Incarnate Word Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>901 Scott</b>		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROSEMARY T. McGRAIL</b>			4. DATE OF DEATH Month Day Year <b>Oct. 12 1963</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>			8. DATE OF BIRTH <b>4-3-1928</b>			9. AGE (last birthday) <b>35</b>			IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Carl W. Hoss</b>			13b. MOTHER'S MAIDEN NAME <b>Hilda Doosack</b>			14. NAME OF HUSBAND OR WIFE <b>Edward McGrail</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Edward McGrail 901 Scott</b>			Address			18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous Cell Carcinoma of the Cervix</b> DUE TO (b) <b>171X</b> DUE TO (c) <b>18 mo</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>1962</b> to <b>Present</b> and last saw her him alive on <b>12 Oct 63</b> Death occurred at <b>1:50 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>Volus Byrne MD</b>		(Degree or title)		22b. ADDRESS <b>4660 Maryland</b>		22c. DATE SIGNED <b>14 Oct 63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 15, 1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>		(State)			
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>OCT 14 1963</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>					

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Dr. John Byrne  
4660 Maryland Ave.

Fo. 1-6349  
3-6

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Ernest W. Spillers*

Licensed Embalmer No.

*4080*

P. O. Address

*St Louis mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.